HIPAA

Consent for Disclosure of Applicant's Protected Health Information

Attachment C

I, (full name): _____,

Social Security Number: _____ - _____ - _____ **Date of Birth:** _____ / _____ / _____

Hereby authorize the Georgia Department of Community Affairs DCA and the programs, agencies and persons listed below to communicate and disclose to one another written and verbal information regarding my protected health information:

- DCA Tenant Based Rental Assistance Program TBRA rent subsidy processing office
- Georgia Money Follows the Person Program MFP
- MFP Direct Provider Agency
- U.S. Department of Housing and Urban Development (HUD)
- Local Public Housing Authority
- Rental Property Owner or Manager
- Current Housing Provider

The purpose of the disclosure is to obtain information used to secure and/or maintain rental assistance and housing through DCA's rent subsidy programs or through a local housing authority.
DCA does not have my permission to disclose the following items: _____
I understand that my medical/health information records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and cannot be disclosed without written consent unless otherwise provided for in the regulations. I understand that by signing this authorization, I am allowing the release of my protected health information. The protected health information in my record may include mental/behavioral health information, information relating to acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), alcohol/drug abuse, and/or a developmental disability.

I understand that I may revoke this consent at any time, except to the extent that disclosures have already been made in reliance on this or any other consent. Revocation may be accomplished by written request and may be for specific items or the entire release. To revoke this consent, mail a signed written request to revoke consent to: Georgia Department of Community Affairs, Office of Special Housing Initiatives, TBRA Program Manager, 60 Executive Park South, N.E., Atlanta, Georgia, 30329-2231.

I understand that this consent remains effective until I am no longer a participant in the DCA TBRA program, unless I specify expiration on the following date, or based on the following event or special condition: _____
I understand that while signing this consent form is not a precondition to being declared eligible for housing assistance, DCA cannot complete the process of delivering such assistance to me unless I sign this consent form. I understand that I may request to inspect or request a copy of information to be used or disclosed, as provided in 45 CFR Section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
Would you like a copy of this consent form? Please initial: ( ) **YES** ( ) **NO**

Signature of Consumer: _____ **Date:**_____

Signature of Witness: _____ **Date:** _____

Signature of Parent/Guardian/Representative:_____ **Date:** _____

Guardian/Representative: please include a description of authority to act on Consumer's behalf:

_____